Frequently Asked Questions Related to the CARE Act Data Report

GENERAL QUESTIONS	
Questions	**Answers**
1. If a multiply-funded service provider completes only one Care Act Data Report (CADR) with data on clients from all CARE Act titles served during the report period, and then sends a copy of the completed report to all grantees of record that fund them, then how will HAB know which client counts have been duplicated?	Duplicate data will be identified using a variety of information provided on the CADR in Section 1, Part 1, such as Tax ID numbers, grantee-of-record number, and/or zip codes. HAB's data contractor will remove all duplicate copies of each service provider report and make sure that only one copy of each provider's report is entered into the final database provided to HAB. Since CADR is still a provider-based report, duplication of clients will occur if the clients receive services from more than one provider.
2. In some instances, a provider may serve clients who would fall under a few different grantees funded under different CARE Act Title programs. For example, one provider in Northern VA may see clients funded under the VA Title II program and the DC Title I EMA. This same provider must report its data to the state of VA and to the DC EMA. Would this provider complete two separate versions of the CADR reports for VA and DC, specifying its data for Title II versus Title I clients respectively?	Each provider should complete the entire CADR for all clients served during the reporting period and send copies to each grantee it contracts with, even if some of the information included on the provider's CADR is not relevant to a particular grantee. The CADR only allows for Title-specific information in Section 6. If a grantee requires more title-specific information, they should request it separately from their provider.
3. Some consortia utilize numerous small providers for special service activities. Should each of these small providers complete a CADR form?	The consortia should continue to report as they have in the past.
4. Should a Title IV grantee with a centralized, client-level database compile and send one CADR to HAB's data contractor?	Yes. Continue to report as you have done in the past.
5. If submitting a complete CADR report via the Web, does the grantee need to send the signed cover page to HAB's data contractor separately?	Yes. The cover page must be mailed or faxed to CARE Act Data Support at CSR, Incorporated.
6. Does the CADR take care of CBC/MAI requirements?	Services provided to clients using CBC/MAI funding must be reported on the CADR, as would any other services. However, grantees are still responsible for reporting CBC/MAI information to HAB separately.
7. Will there be a penalty for a large number of unknowns reported for specific items on the CADR?	Grantees are expected to work with their service providers to establish procedures for collecting all information on the CADR for all clients served during the reporting period. Project officers within the individual Title programs will be notified about grantees with large amounts of unknowns or missing data. Title programs will make decisions about how to handle such deficiencies.
8. If treating an affected client, does the infected family member or partner need to be a client of the agency in order to count the affected individual?	Yes, in order to consider this individual as a client who receives CARE Act services, the individual must be linked to a client with HIV infection who received services from your agency during the reporting period.

Questions	Answers
9. What constitutes the end of the reporting year? If a provider only asks information every six months and the six-month period does not fall at the end of the reporting period, are they required to ask the information again?	A provider/grantee should report the most recent information they have for each client. They are not required to ask these questions of their clients again at the end of the reporting period. Grantees/providers can follow their own schedule.
10. Do program and agency mean the same thing or are they different?	For the purpose of the CADR they mean the same thing.
11. How should Title IV providers and grantees complete the CADR?	Continue to report as you have in the past. If the grantee has a centralized system for collecting data, then the grantee should complete one report and submit it to HAB's data contractor or via the web. If no centralized data collection system exists, each service provider (reporting entity) should complete an individual CADR for the services they provided and submit the form to their grantee who then completes a cover page and submits all the provider reports together to the data contractor.
12. Should adolescents-only programs report using the CADR?	Yes, the youth programs should report using the CADR. They should check the Title IV Adolescent/Youth Initiative as their source of funding (this category will be added to the form) and complete all applicable sections of the report (including Section 6.2).

SECTION 1: SERVICE PROVIDER INFORMATION

Questions	Answers
1. Where contact information is requested on the CADR, is HAB looking for the primary service provider contact or a data contact?	HAB would like contact information for the person responsible for the provider's data (and whom HAB's data contractor should contact to resolve any data issues on the CADR). On the CADR cover page, HAB is requesting the contact person for the grantee.
2. Which grantees and service providers should be reporting on all clients who received services eligible for CARE Act funding versus only those clients who received services funded by the CARE Act? What is the difference between the two reporting scopes?	HAB's preference is that all grantees will report on all clients who received services eligible for CARE Act funding (Reporting Scope 01) during the reporting period. However, grantees may contact their project officer at HAB for permission to report using the 'funded' (02) reporting scope. Service providers should contact their grantee to determine which reporting scope the grantee would like its service providers to use. Under the funded reporting scope (02), only those clients who receive a CARE Act-funded service are reported. Under the eligible reporting scope (01), all clients who receive a service eligible for CARE Act funding are reported, even if that service was not paid for with CARE Act funds. Often CARE Act funds are blended with other grants and reimbursement funds and the provision of individual service units cannot be identified by distinct funding stream within provider organizations. The eligible reporting scope (01) thus allows for a wider spectrum of data collection related to CARE Act services.

Questions	Answers
3. For reporting scope 01, which services are eligible for Ryan White CARE Act funding?	Services eligible for CARE Act funding are listed in Section 3, Item 35 on the CADR. Under reporting scope 01, grantees and service providers are responsible for reporting on all clients receiving services eligible for CARE Act funding.
4. Ryan White CARE Act funds are used as payer of last resort for a Title III medical service. With respect to scope 02, would a Title III-only recipient be reported under scope 02?	The Title III grantee would select the eligible reporting scope (01) and report on all clients who received any services eligible for Title III funding. Title III grantees may only use the funded reporting scope (02) if they have permission from their HAB project officer.
5. Should SPNS, AETC, or DRP funding be reported in Item 10?	No, these funding sources should not be reported in Item 10.
6. A Title I EMA subcontracts with an agency for technical assistance and quality management. How should this be reported?	The subcontractor completes a CADR through Item 11 only (checking off the two support services) and stops. The subcontractor then submits this CADR to the Title I EMA.
7. Regarding the funding received section, what should be reported—the amount allocated or planned?	Report only the amount actually received during the reporting period.
8. Should providers subtract unexpended funds from the funding reported on the CADR?	No. Providers should report on all funding received whether expended or not during the reporting period.
9. For Item 23, funds expended on oral health care, does this apply only to Dental Reimbursement Program (DRP) grantees?	No, this does not apply to DRP grantees. The DRP does not use the CADR for annual reporting. Only Title I, II, III, and IV grantees and their service providers should report on this item for all clients who received oral health care during the reporting period.

SECTION 2: CLIENT INFORMATION

Questions	Answers
1. Is there a standard breakdown for gender?	The classifications currently used in the gender Item 26 represent the new HAB standard for annual reporting of gender.
2. Is the way that the ethnicity/race questions are asked on the CADR the standard for all agencies receiving Federal funding?	Yes, all agencies receiving Federal funding must comply with the new Office of Management and Budget (OMB) standards for capturing and reporting race and ethnicity by 2003; HAB began asking for data in this way in 2002.
3. How should providers report those clients who do not self-report a race?	All clients should be asked the ethnicity and race questions on the CADR. If a client does not identify an ethnicity or race, then the client should be reported in the unknown/unreported category.
4. Why are the age categories not standardized across HRSA and CDC?	HAB staff has worked with CDC staff to standardize age categories to the extent possible. The age categories in the CADR correspond to the HRSA categories; other CDC programs may vary in their use of age categories.
5. How do you report when you have a client who is initially diagnosed as HIV positive, but is later shown—through subsequent testing results—to be HIV negative?	You should report whatever the diagnosis is at the end of the reporting period.

Questions	Answers
6. How are HIV-exposed infants categorized on the CADR?	If their status is known (HIV positive or negative), then it should be reported on the appropriate line. If their HIV status is unknown, then it should be reported as such.
7. How can you report someone whose HIV status is unknown under the CARE Act?	The person should be reported as HIV status unknown/unreported (affected).
8. How should a provider report a client who was previously HIV negative and receiving services, but was re-tested in the current reporting year and found to be HIV positive?	If the client was reported as an affected individual in the past, then they would be reported as an "active client, continuing in the program." However, if the client was never reported on in previous years, the client should be reported as 'New.' The client would also be reported as HIV positive in the appropriate sections.
9. In Item 24, who is included under the HIV negative category?	Only 'affected' clients who are HIV negative, or clients whose HIV status is unknown, fall under the HIV negative category. (Note: A category for unknown clients will be added to Item 24 in the near future). To be considered affected, a client must be either a family member, spouse, or partner who has been 'affected' by a client's HIV-positive status. See the glossary in the CADR instructions for more information.
10. Should the total in Item 24 be equal to Section 6.2 totals?	These totals should be equal only if the agency is funded only by Title IV.
11. In Item 30, who is included in a household?	A household can be made up of family members, a spouse, partner, or non-family members that reside together. See the CADR instructions for more information.
12. For Item 30, household income, clients who are HIV positive and affected are listed in two separate columns, but some households include both HIV positive and affected clients. How should this be reported?	The total household income for each client receiving services and thus reported on the CADR, would be the income of all HIV positive and affected clients living in the household. Each client would be reported separately but if they reside in the same household, the same income information would be entered for each client.
13. How should providers categorize clients who are homeless in Items 30 and 31?	In Item 30, homeless clients should be reported in their income category (which will constitute their household income). If the clients report that they have no income, they should be counted in the 'Equal to or below the Federal poverty line' category or the 'Unknown/unreported' category, depending on the response of the client. The instructions for Item 31 include homeless clients in the definitions for the 'non-permanently housed' category.
14. If a client is discharged and then later re-enters the program, should the individual be counted as a new client?	The client who returns for care after an extended absence should not be considered new unless past records of their care are not available.
15. What is the definition of "inactive"?	Each individual grantee/provider determines the period of time that must pass before a client is considered inactive.

SECTION 3: SERVICE INFORMATION	
Questions	**Answers**
1. Many grantees wanted the columns for affected clients to be opened up on the CADR report so they could report data for rows a.–i. on these clients. This issue of inability to record services for affected clients seemed to be a major one.	Technically, grantees are not supposed to be providing health-related services using CARE Act funds to affected individuals, despite the fact that this may have been allowed in the past. Therefore, these cells will not be opened up.
2. Should providers be discouraged from using unknown/unreported for outreach services?	Yes, this category should **NOT** be used for reporting any anonymous clients. If grantees or service providers conduct outreach activities in large settings such as health fairs, these individuals should not be included on the CADR, unless they are accounted for in Section 2 with demographic information.
3. What constitutes a visit?	"Visit" should be defined by your program. However, a client may only have one visit for each service category per day. For a residential substance abuse treatment center, each day in a residential facility equals one visit. For example, if a client spends 20 days in a residential facility, this counts as 20 visits.
4. In Item 35, what is the rationale for not recording visits for services k–af?	To reduce burden, a decision was made to ask this information for only critical, health care-related services.
5. Regarding funds for adherence treatment—as case manager, should the service be reported under case management or adherence?	If at the time of the case management visit, treatment adherence services were provided, it is appropriate to report under both.
6. Should grantees and service providers report on fee-for-service treatments or services on the CADR?	Providers should track all services that they pay for.
7. Regarding funds for client advocacy—as case manager, should the service be reported under case management or client advocacy.	If at the time of the case management visit, client advocacy services were provided, it is okay to report under both.
8. Under which service category should providers report face-to-face case management?	Face-to-face case management or any other type of case management provided (i.e., telephone) should be counted under case management as one visit.
9. Under which service category should providers report child respite care?	Child respite care falls under 'Child care services.' However, this category does not include childcare for working parents; it only includes childcare when parents need someone to watch children while they are receiving services.
10. In Item 35, how should a provider document mental health services for an affected client?	These individuals should be reported under 'Psychosocial support services.'
11. Can Ryan White CARE Act funds be used to provide services to prisoners?	Please see ***HAB Policy Notice 01-01: Use of Ryan White CARE Act Funds for Transitional Social Support and Primary Care Services for Incarcerated Persons.*** Visit the HAB web site at http://www.hab.hrsa.gov/l/notice0101.htm for more information.
12. Under which service category should a provider report groceries, food vouchers, and food stamps?	Report these services in Item 35 under 'Emergency Financial Assistance.' The definition will be updated to reflect this information.

Questions	Answers
13. If a Title III grantee or provider does not provide substance abuse services, but provides substance abuse referrals, do they have to set up some system to track services provided through referrals in order to have numbers to report in Items 35d and 35e?	For reporting purposes, Title III grantees and service providers would report these clients in Items 35aa and 63. The Title III program requires grantees to be able to track this information to see if the client received the service.
14. How does HAB define "referral" in Item 35?	The definition of a referral is listed in the glossary section of the CADR Instructions. It states that a referral for health care/supportive services is: "The act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made formally from one clinical provider to another, within the case management system by professional case managers, informally through support staff, or as part of an outreach program."

SECTION 4: HIV COUNSELING AND TESTING (*C*&T)

Questions	Answers
1. Which service providers should complete this section?	Providers funded under any and all titles should complete this section. C&T is a requirement for Title III and IV grantees and can now be funded as components of Early Intervention Services for Title I and II grantees.
2. Should grantees report on all clients who received HIV Counseling and Testing (C&T) during the report period or only on those clients who received C&T that was funded by CARE Act funds?	Grantees/providers who selected the eligible reporting scope (01) and who provided C&T during the reporting period, must complete all items in Section 4 on all individuals who received C&T, regardless of who paid for the testing. Grantees/providers who selected the funded scope (02), and used CARE Act funds to pay for the service must complete section 4 for only those clients who received C&T as a CARE Act-funded service. Those who selected funded reporting scope (02) and provided C&T, but did not use CARE Act funds for these services, can answer yes to Item 36, no to Item 37, skip Items 38–44, and continue with Section 5 of the report.
3. Under HIV counseling and testing, if someone tests negative, should they be reported on the CADR?	These individuals are accounted for in Items 38–41 on the CADR. However there is no place specifically to report the number of individuals who test negative.
4. Can Title I agencies use CARE Act funds for HIV counseling and testing?	Yes, if C&T is provided as a component of the early intervention services for Title I and II.
5. For Items 36–44, how can anonymous clients be entered into CAREWare?	Anonymous clients cannot be entered into CAREWare.

SECTION 5: MEDICAL INFORMATION	
Questions	**Answers**
1. For Item 47, TB skin test, are clients only counted if the test is planted and read?	Item 47 refers to TB tests planted.
2. What is the definition of ”treatment” in item 47? Does it mean prescribed, in progress, or completed?	In Item 47, “treatment” refers to treatment that has been initiated, which can include a physician writing a prescription for medication (understanding that the physician might not have information regarding the patient’s filling the prescription or taking the medication).
3. Is client self-report acceptable for Items 47–52?	No.
4. In Item 49, if a client receives both dual and triple combination therapy in one reporting year, how should they be reported on the CADR?	Count the client under the therapy they were receiving at the end of the reporting year.
5. How should infants be reported in Section 5?	If the Infants are confirmed to be HIV positive, then they should be reported in Section 5. If their HIV status is still unknown or indeterminate, then they should not be reported in this section because it should include only clients who are HIV positive.
6. How is a woman who is pregnant for a few weeks in one reporting period and then delivers in the next reporting period reported in Items 51–55?	In this situation the woman would be reported in Items 51 and 53 for both reporting years. The child she delivers would only be reported under Items 54 and 55 during the second reporting year (since that was when the child was delivered).
7. What is the definition of “Medical Service Provider”?	A medical service provider is any service provider who provided ambulatory/outpatient medical care (Item 35, service category “a”). However, remember that this section should also be completed by authorized personnel who have access to this information, such as case managers.
SECTION 6: DEMOGRAPHIC TABLES/TITLE-SPECIFIC DATA FOR TITLES III AND IV	
Questions	**Answers**
1. In Items 58 and 59, under which response category should a provider report children who were exposed to HIV by sexual abuse?	Report these children under the ‘other’ exposure category in the tables in Items 58, 59 and 68.
2. When a multiply-funded provider completes the Title IV information in Section 6.2, should the provider report only those served under Title IV programs?	The information reported in Section 6.2 should include only those served under Title IV programs.
3. A Title IV grantee is also a Title II provider. How does this grantee report a 60-year-old male receiving case management services under Title II?	Report this client in other relevant sections of the CADR (i.e., Sections 2 and 3); however, do not report him in Section 6.2.

SECTIONS 7 AND 8: APA/ADAP AND HIP INFORMATION	
Questions	**Answers**
1. How should a provider report ADAP funds used to pay for clients' health insurance?	Report on all clients who received this service in Section 7 (APA/ADAP Information). If you also complete Section 8: HIP Information, you should report the ADAP funding used in Item 9.
Questions	**Answers**
2. A Health Insurance Continuation Program (not directly CARE Act funded) is conducted under ADAP. Which sections of the CADR should be completed in order to capture the data from this program?	If ADAP funds were used to pay for health insurance, then complete the ADAP section but not the HIP section.
3. Under Title III, should emergency pharmaceutical assistance (340-B) be reported under Section 7?	No. For reporting purposes, Title III grantees should report this under Emergency Financial Assistance (Section 3, Item 35r). However, for programmatic information it falls under primary medical care. Note that there is a distinction between administering a **formal** pharmaceutical program (offering ongoing assistance) and providing emergency funding. Several grantees/consortia have developed local APAs. If money is allocated for prescriptions on an ongoing basis, that information should be reported in Section 7.